

FILED NOV 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHSTATE FILE NUMBER 40610
5213

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		d. STREET ADDRESS 1620 Troost	
3. NAME OF DECEASED (Type or print) First Infant Middle 0 Last Smith		4. DATE OF DEATH Month October Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 12
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Canary V. Smith	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Canary V. Smith, mother 1620 Troost
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 776X
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 10-13-57 to 10-14-57 and last saw her alive on 10-14-57 Death occurred at 2:25 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Th. S. Peterson M.D. (Degree or title)		22b. ADDRESS 600 E. 22nd St.	
22c. DATE SIGNED 10-31-57			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE 11-7-57	23c. NAME OF CEMETERY OR CREMATORY Luke	23d. LOCATION (City, town, or county) (State) Kansas City MO
24. FUNERAL DIRECTOR Th. S. Peterson		25. DATE RECD. BY LOCAL REG. 11-6-57	26. REGISTRAR'S SIGNATURE Reva Minshall

(Licensed Embalmer's Statement on Reverse Side)

W.R. Peterson : USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER



I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Not Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Am. A. Schuyler
3089

Licensed Embalmer No. 3089

P. O. Address KC MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.